MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 03684

3687 CERTIFICATE OF DEATH

Reg. Dist. No. 185

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Harford — MARYLAND
CITY (If outside corporate limits, write RURAL OR TOWN and give nearest town) Havre de Grace 24 | LENGTH OF STAY (in this place) Life
HOSPITAL OR INSTITUTION OR STREET ADDRESS 734 Ontario St. X

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md — COUNTY Harford
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Havre de Grace 2.4
STREET ADDRESS (If rural give location) 734 Ontario, St.

3. NAME OF DECEASED: (Type or Print) (First) Leona (Middle) Keen (Last) Barnard
4. DATE OF DEATH: (Month) April (Day) 7, (Year) 1954

5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE Last birthday:	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Widowed	Oct. 22, 1877	76 yrs.				

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Home Retired
11. BIRTHPLACE (State or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Wm J. Keen
14. MOTHER'S MAIDEN NAME: Susanna Jefferson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) —
(If Yes, give war or dates of service) —
16. SOCIAL SECURITY No.: —
17. INFORMANT & ADDRESS: Mrs. Ada Keen Ashe Havre de Grace, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — Interval Between Onset And Death

331 X
Immediate cause (a) Cerebral Hemorrhage
DUE TO

Antecedent causes (s)
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.
(b)
DUE TO
(c) Cerebral Sclerosis - Hypertension

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURED While at Work ☐ Not While At Work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan. 2, 1953, to Apr. 7, 1954, that I last saw the deceased alive on Apr. 7, 1954, and that death occurred at 930 A.M.; from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
C. L. Lewis	M.D.	Havre de Grace Md	Apr. 9-1954

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	Apr. 10 1954	Angel Hill	Havre de Grace	Md.

DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Apr. 9-1954	C. L. Lewis M.D.	R. Madison Mitchell	Havre de Grace, Md.

VS. A15

RECEIVED
APR 12 1954
BUREAU V. S.

03685

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3698

CERTIFICATE OF DEATH

Reg. Dist. No. 182

1. PLACE OF DEATH: COUNTY Harford MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Darlington R.D.
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Harford
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Darlington R. D.
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED: (Type or Print) (First) Rosie (Middle) B. (Last) Barnes
4. DATE OF DEATH: (Month) (Day) (Year) April 10, 1954
5. SEX: Female
6. COLOR OR RACE: Colored
7. SINGLE, MARRIED, ~~WIDOWED, DIVORCED~~ (Specify): Married
8. DATE OF BIRTH: Unknown
9. AGE last birthday: About 72 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework
10B. KIND OF BUSINESS OR INDUSTRY: at Home
11. BIRTHPLACE (State or foreign country): Cecil Co., Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Richard Berry
14. MOTHER'S MAIDEN NAME: Jane Body

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service) No
16. SOCIAL SECURITY NO. No
17. INFORMANT & ADDRESS: Mr. Wayman Barnes Darlington, Md.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

422.1 IMMEDIATE CAUSE (A) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: Immed

ANTECEDENT CAUSE (S) DUE TO (B) Arteriosclerosis Cardiovascular dis — 6 yr

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21B. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.
21E. INJURY OCCURRED While at work ☐ Not while at work ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan, 1949, to April 10, 1954, that I last saw the deceased alive on April 4, 1954, and that death occurred at 1250 PM, from the causes and on the date stated above.

SIGNATURE Malcolm Dudley Phillips M.D. ADDRESS Darlington Md DATE SIGNED 4/10/54

23. BURIAL, ~~CREMATION, REMOVAL (SPECIFY)~~ Burial
DATE THEREOF April 13, 1954
NAME OF CEMETERY OR CREMATORY Hosanna Am
LOCATION (City, town, or county) Harford Co., Md. (State)

DATE REC'D BY LOCAL REGISTRAR April 11, 1954
REGISTRAR'S SIGNATURE C. W. Kirk
24. FUNERAL DIRECTOR H. S. Bailey
ADDRESS Darlington, Md.

VS. A15 — 10 - 53

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
APR 29 1954
BUREAU V. S.

3699 03686

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 185

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
COUNTY Harford MARYLAND
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN Joppa
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md COUNTY Harford Co
CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN
STREET ADDRESS (If rural, give location) Manrell Lane Joppa Md

3. NAME OF DECEASED: (Type or Print) (First) Norwood (Middle) (Last) Blake

4. DATE OF DEATH (Month) April (Day) 4 (Year) 1954

5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
male	colored	Married	6-5-1917	36 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):	10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):	12. CITIZEN OF WHAT COUNTRY?
Laborer		Maryland	U.S.A.

13. FATHER'S NAME: Alexander Blake

14. MOTHER'S MAIDEN NAME: Grace Strawder

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.:	17. INFORMANT & ADDRESS:
		Ellen Blake Joppa Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH: (Interval Between Onset and Death)

002X

Immediate cause (a) Pulmonary Hemorrhage

DUE TO

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (b) Pulmonary Tuberculosis

DUE TO

(c)

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH

19a. DATE OF OPERATION:	19b. MAJOR FINDING OF OPERATION:	20. AUTOPSY? Yes ☐ No ☒

21a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY	21c. (City or town) (County) (State)

21d. TIME (Month) (Day) (Year) (Hour) OF INJURY M.	21e. INJURY OCCURRED While at work ☐ Not while at work ☐	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE Gerald C Palmer M. D. CHIEF MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAM. ☒ DATE SIGNED 4/4/54

23. BURIAL, CREMATION, REMOVAL (Specify):	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	4-8-54	Mt Calvary Mem Gdns	Md

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR ADDRESS
4-5-54	A W Hedrick	Rayner Sanders 217 E Preston St

VS. A15A - 5 - 53

April 4 57

Palmary hemorrhage
Palmary tuberculosis

Gerald C Palmer

4/4 157

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 03687

3700 CERTIFICATE OF DEATH

Reg. Dist. No. 182

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
COUNTY Harford
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Forest Hill
LENGTH OF STAY (in this place) 6 mos.
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md COUNTY Harford
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Forest Hill
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED: (Type or Print) (First) James (Middle) Walter (Last) Bruffey

4. DATE OF DEATH: (Month) April (Day) 13 (Year) 1954

5. SEX: M

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: Dec 1885

9. AGE last birthday: 68 yrs. IF UNDER 1 YEAR: Months, Days; IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired: Carpenter

10b. KIND OF BUSINESS OR INDUSTRY: General Building

11. BIRTHPLACE (State or foreign country): Lobelia, W. Va

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Wm Aaron Bruffey

14. MOTHER'S MAIDEN NAME: Martha Curne

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT & ADDRESS: Minnie Jane Bruffey, Forest Hill, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Lymphosarcoma — Interval Between Onset And Death

DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) DUE TO

(c)

200.1

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. INJURY OCCURED While at Work ☐ Not While At Work ☐ HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 11/1, 1953, to 4/13, 1954, that I last saw the deceased alive on April 2 1954, and that death occurred at 1:15 A M, from the causes and on the date stated above.

SIGNATURE (Degree or title) Gerald C Palmer MD ADDRESS Bel Air Md. DATE SIGNED 4/13/54

23. BURIAL, CREMATION, REMOVAL (Specify) Burial DATE THEREOF Apr 15 1954 NAME OF CEMETERY OR CREMATORY Jarrettsville LOCATION (City, town, or county) (State) Jarrettsville, Harford Co. Md

DATE REC'D BY LOCAL REGISTRAR 4/14/54 REGISTRAR'S SIGNATURE Priscilla Fawwood

24. FUNERAL DIRECTOR Martin G. Kurtz ADDRESS Jarrettsville, Md.

VS. A15

RECEIVED
APR 19 1954
BUREAU V. S.

3701

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03688 Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 182

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15A - 5 - 53

1. PLACE OF DEATH:
COUNTY Harford — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Fallston
LENGTH OF STAY (in this place) 2 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Harford
CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN Fallston
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED: (Type or Print) (First) Rufus (Middle) Edgar (Last) Burns

4. DATE OF DEATH (Month) April (Day) 3 (Year) 1954

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday:	IF UNDER 1 YEAR: Months	Days	IF UNDER 24 HRS.: Hours	Min.
male	White	Single	Oct. 8, 1905	48 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer	Farm	Maxton, N.C.	U.S.

13. FATHER'S NAME: William P. Burns

14. MOTHER'S MAIDEN NAME: Mary L. Scott

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.:	17. INFORMANT & ADDRESS:
no	none	John L. Burns, Fallston, Maryland.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH: — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Hemiplegia

DUE TO

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

(b) DUE TO

(c)

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION:	19b. MAJOR FINDING OF OPERATION:	20. AUTOPSY? Yes ☐ No ☐

21a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY	21c. (City or town) (County) (State)

21d. TIME (Month) (Day) (Year) (Hour) OF INJURY	21e. INJURY OCCURRED While at work ☐ Not while at work ☐	21f. HOW DID INJURY OCCUR?
M.		

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE Howard C. Palmer M. D. — CHIEF MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAM. ☐ — DATE SIGNED 4/2/54

23. BURIAL, CREMATION, REMOVAL (Specify):	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Removal	Apr. 5, 1954	Maxton Funeral Home	Maxton, Robeson, N.C.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR ADDRESS
4/7/54	Priscilla Fonvood	Howard K. Mc Comas & Son, Abingdon, Md.,

RECEIVED
APR 9 1954
BUREAU V. S.

MARYLAND

STATE DEPARTMENT OF HEALTH 03689

3688

CERTIFICATE OF DEATH

Reg. Dist. No. 17

M

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH — COUNTY: Harford — MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): aberdeen
LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 438 Bonnett St.

2. USUAL RESIDENCE (HOME) OF DECEASED — STATE: Maryland — COUNTY: Harford
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): aberdeen
STREET ADDRESS (If rural, give location): 438 Bonnett St.

3. NAME OF DECEASED (Type or Print): (First) John (Middle) — (Last) Byrne

4. DATE OF DEATH: (Month) 4 (Day) 16 (Year) 1954

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: 4/13/1953
9. AGE last birthday: 1 yrs. — If under 1 year: Months / Days — If under 24 hrs: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired): Infant
10b. KIND OF BUSINESS OR INDUSTRY: Infant
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: James J. Byrne
14. MOTHER'S MAIDEN NAME: Consuelo Brancci

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service)
16. SOCIAL SECURITY No.: —
17. INFORMANT AND ADDRESS: James J. Byrne aberdeen md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

475X

Immediate cause (a) Pneumonia — 12 hr.

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Acute upper respiratory infection — 7 days

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Mongolism — 1 yr.

19a. DATE OF OPERATION: None
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) None m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4-13-, 1953, to 4-16-, 1954, that I last saw the deceased alive on 4-15-, 1954, and that death occurred at 5:00 A m., from the causes and on the date stated above.

SIGNATURE: [signature] (Degree or title) M.D. ADDRESS: Aberdeen Md. DATE SIGNED: 4-16-54

23. BURIAL, CREMATION REMOVAL (Specify): Removal
DATE: 4/19/54
NAME OF CEMETERY OR CREMATORY: Holy Savior
LOCATION (City, town, or county): Bethlehem (State): Pa.

DATE REC'D BY LOCAL REG.:
REGISTRAR'S SIGNATURE:
24. FUNERAL DIRECTOR: John G. Tarring — ADDRESS: aberdeen md.

APR 21 1
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

03690

3702 CERTIFICATE OF DEATH

Reg. Dist. No. 182

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Type correct age is specially important. Physician: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH: COUNTY Harford; MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Black Horse; LENGTH OF STAY (in this place) 17 yrs; HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md; COUNTY Harford; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Black Horse; STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print): (First) HATTIE (Middle) Viola (Last) CAIRNES

4. DATE OF DEATH: (Month) April (Day) 30 (Year) 1954

5. SEX: F.

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): widow

8. DATE OF BIRTH: Dec. 11, 1876

9. AGE last birthday: 77 yrs. If under 1 year: Months 4, Days 19. If under 24 hrs.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Companion

10b. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): Stewartsville, Md

12. CITIZEN OF WHAT COUNTRY: U.S

13. FATHER'S NAME: Rev Thomas Ward

14. MOTHER'S MAIDEN NAME: Elizabeth Meiler

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY No.:

17. INFORMANT AND ADDRESS: Mrs. Howard Turner, White Hall, Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

581.1

Immediate cause (a) Hemorrhage from Esophageal Varices

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) CIRRHOSIS of LIVER

(c)

INTERVAL BETWEEN ONSET AND DEATH:

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. none

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE):

TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 5, 1954, to April 30, 1954, that I last saw the deceased alive on April 30, 1954, and that death occurred at 7:00 p. m., from the causes and on the date stated above.

SIGNATURE (Degree or title): Willard P. Hudson M.D. ADDRESS: Forest Hill, Md DATE SIGNED: 5/6/54

23. BURIAL, CREMATION, REMOVAL (Specify): Burial; DATE THEREOF: May 3, 1954; NAME OF CEMETERY OR CREMATORY: Bethel; LOCATION (City, town, or county) (State): Madonna, Harford Co. Md.

DATE REC'D BY LOCAL REG. 5/2/54; REGISTRAR'S SIGNATURE: Priscilla Fonwood

24. FUNERAL DIRECTOR: Martin L. Kurtz; ADDRESS: Darlington, Md.

RECEIVED
MAY 7 1954
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

03691

3703

CERTIFICATE OF DEATH

Reg. Dist. No. 181

1. PLACE OF DEATH: COUNTY HARFORD MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN ~~Edgewood~~ Aberdeen PG
LENGTH OF STAY (in this place) 6 months
HOSPITAL OR INSTITUTION OR STREET ADDRESS USA Hospital Aberdeen Proving Ground, Md

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE MARYLAND COUNTY HARFORD
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Edgewood
STREET ADDRESS (If rural, give location) 37 Star St

3. NAME OF DECEASED (Type or Print) (First) JAMES (Middle) ELLIS (Last) CHRISTIAN

4. DATE OF DEATH (Month) April (Day) 4 (Year) 1954

5. SEX Male
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single
8. DATE OF BIRTH 1 Oct 53
9. AGE last birthday yrs. If under 1 year Months 6 Days 4 If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None
10b. KIND OF BUSINESS OR INDUSTRY None
11. BIRTHPLACE (State or foreign country) W.Va.,
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME ELLIS CHRISTIAN
14. MOTHER'S MAIDEN NAME Dixie (NMI) Mullins

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. None
17. INFORMANT ELLIS Christian - Father Raysal, W.Va

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

7524

Immediate cause (a) Cystine Disease (Inborn error of metabolism)

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Urinary Retention; Cardiac failure

(c) Hydrocephalus, Congenital.

INTERVAL BETWEEN ONSET AND DEATH: Jan 14, 54

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☒ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 12 Mar, 1954, to 4 Apr, 1954, that I last saw the deceased alive on 4 Apr, 1954, and that death occurred at 8:30 p.m., from the causes and on the date stated above.

SIGNATURE Milton Gordon (Degree or title) Capt. M.C. ADDRESS USAH Aberdeen PG, Md DATE SIGNED 4 Apr 54

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE THEREOF Apr 7, 1954
NAME OF CEMETERY OR CREMATORY Mullins
LOCATION (City, town, or county) (State) Raysal McDowell W Va

DATE REC'D BY LOCAL REG. April 7-54
REGISTRAR'S SIGNATURE [illegible]
24. FUNERAL DIRECTOR Howard R. McComas & Son ADDRESS Abingdon Md

J 1V03 9 1V 99 1

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
APR 9 1954
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3704 CERTIFICATE OF DEATH

03692 Reg. Dist. No. 181

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Harford — STATE MARYLAND — CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural Havre de Grace — LENGTH OF STAY (in this place) Life — HOSPITAL OR INSTITUTION OR STREET ADDRESS R.D. #1

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. — COUNTY Harford — CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural Havre de Grace — STREET ADDRESS (If rural give location) R.D. # 1

3. NAME OF DECEASED: (Type or Print) (First) Elsie (Middle) Oleta (Last) Coen

4. DATE OF DEATH: (Month) Apr. (Day) 17 (Year) 1954

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: Dec. 23, 1877

9. AGE last birthday: 76 yrs. — IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country) Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John T. Cole

14. MOTHER'S MAIDEN NAME: Margaret Mahan

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) — (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.:

17. INFORMANT & ADDRESS: Mr. Chas. S. Coen Havre de Grace R.D. #1

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause — (a) 331X Hemiplegia Cerebral Hemorrhage — Interval Between Onset And Death

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. — DUE TO (b) Cerebral sclerosis

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: — 19b. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc) — (CITY OR TOWN) — (COUNTY) — (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURED While at Work ☐ Not While At Work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4-16, 1954, to Apr. 17, 1954, that I last saw the deceased alive on Apr. 17, 1954, and that death occurred at 6 P.M., from the causes and on the date stated above.

SIGNATURE (Degree or title) — ADDRESS — DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (Specify) Burial — DATE THEREOF Apr. 20, 1954 — NAME OF CEMETERY OR CREMATORY: Wesleyan Chapel — LOCATION (City, town, or county) Harford Co. — (State) Md.

DATE REC'D BY LOCAL REGISTRAR Apr 20-54 — REGISTRAR'S SIGNATURE Nellie K. [illegible]

24. FUNERAL DIRECTOR R. Madison Mitchell — ADDRESS Havre de Grace, Md.

VS. A15

RECEIVED
APR 21 1954
BUREAU V. S.

3689

03693

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 1 .....

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
COUNTY Harford MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Havre De Grace
LENGTH OF STAY (In this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY ~~Baltimore~~
CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN Baltimore
STREET ADDRESS (If rural, give location) 3003 Oakcrest Avenue

3. NAME OF DECEASED: (Type or Print) (First) Edward (Middle) G (Last) Conrad
4. DATE OF DEATH (Month) April (Day) 6 (Year) 19 54
5. SEX: male
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): married
8. DATE OF BIRTH: Oct. 24, 1904
9. AGE last birthday: 49 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): Minister
10b. KIND OF BUSINESS OR INDUSTRY: Presbyterian Church
11. BIRTHPLACE (State or foreign country): Baltimore, Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Louis Conrad
14. MOTHER'S MAIDEN NAME: Alice Norwood
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT & ADDRESS: Mrs. Elizabeth B. Conrad, 3003 Oakcrest Ave.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:
Immediate cause (a) Accidental Drowning
DUE TO
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last
(b) ..... DUE TO
(c)
INTERVAL BETWEEN ONSET AND DEATH

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH

19a. DATE OF OPERATION:
19b. MAJOR FINDING OF OPERATION:
20. AUTOPSY? Yes ☐ No ☒

21a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
21b. PLACE (Home, farm, factory, OF street, office bldg., etc.) INJURY Susq. Canal River
21c. (City or town) Havre de Grace (County) Harford (State) Md
21d. TIME OF INJURY (Month) 4/6/54 (Day) (Year) (Hour) 1P M.
21e. INJURY OCCURRED While at work ☒ Not while at work ☐
21f. HOW DID INJURY OCCUR? Plane crashed in River

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE Gerald C Palmer M. D.
CHIEF MEDICAL EXAMINER ☒
DEPUTY MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAM. ☐
DATE SIGNED 4/6/54

23. BURIAL, CREMATION, REMOVAL (Specify): Burial
DATE THEREOF Apr. 9, 1954
NAME OF CEMETERY OR CREMATORY Moreland Memorial Park
LOCATION (City, town, or county) (State) Baltimore, Maryland

DATE REC'D BY LOCAL REG. 4/7/54
REGISTRAR'S SIGNATURE A. W. Heidrick
24. FUNERAL DIRECTOR ADDRESS Leonard J. Ruck, 5305 Harford Road #14

GE

VS. A15A - 5 - 5

03694

MARYLAND STATE DEPARTMENT OF HEALTH

3705

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 180

MARGIN RESERVED FOR BINDING. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK.

VS. A15

1. PLACE OF DEATH: COUNTY Harford — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Edgewood
LENGTH OF STAY (in this place) 72 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Harford
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Edgewood
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print): (First) MORRIS (Middle) MATTHEW (Last) COULTER
4. DATE OF DEATH (Month) April (Day) 27, (Year) 19 54

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months / Days	If under 24 hrs.: Hours / Min.
male	white	Widowed	5/11/1861	92 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Fisherman	Commercial	Maryland	U.S.

13. FATHER'S NAME: Leon Coulter
14. MOTHER'S MAIDEN NAME: unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): no
16. SOCIAL SECURITY NO.: none
17. INFORMANT AND ADDRESS: Clarence Coulter, Edgewood, Maryland.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
44.3X Immediate cause	(a) Acute Congestive Failure, Pulmonary Edema	4 hours
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Hypertensive Cardio-Vascular Disease	15 yrs
	(c) Arteio sclerosis	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	Cerebral Vascular Accident, old, recovered.	

19a. DATE OF OPERATION — 19b. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) — PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY — (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURRED While at Work ☐ Not While At work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 27 APRIL, 19 54, to 27 APRIL, 19 54, that I last saw the deceased alive on 27 APRIL, 19 54, and that death occurred at 11:10 P m., from the causes and on the date stated above.

SIGNATURE (Physician or title) Harold S. Palmer M.D. Deputy Medical Examiner — ADDRESS — DATE SIGNED
Philip W. Newman M.D. 307 Hickory Ave., Bel Air, Md. 28 April 54

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Apr. 30, 1954	Cokesbury	Abingdon, Harford, Maryland.

DATE REC'D BY LOCAL REG. April 30 1954 — REGISTRAR'S SIGNATURE: Marie M Mouledal — 24. FUNERAL DIRECTOR AND ADDRESS: Howard K. Mc Comas & Son, Abingdon, Md.,

RECEIVED
MAY 4 1954
BUREAU V. S.

03695

Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 182

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A - 5 - 53

1. PLACE OF DEATH:
COUNTY Harford MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Bel Air
LENGTH OF STAY (in this place) 1 yr
HOSPITAL OR INSTITUTION OR STREET ADDRESS 122 Penna. ave.

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Harford
CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN Bel Air
STREET ADDRESS (If rural, give location) 122 Penna. ave.

3. NAME OF DECEASED: (Type or Print) (First) Leon (Middle) — (Last) Hall

4. DATE OF DEATH (Month) April (Day) 19 (Year) 19 54

5. SEX: Male

6. COLOR OR RACE: Colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single

8. DATE OF BIRTH: Nov. 26 1898

9. AGE last birthday: 55 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): Janitor

10b. KIND OF BUSINESS OR INDUSTRY: U.S. Govt. Agcy.

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Hanna Hall

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 217-03-6431

17. INFORMANT & ADDRESS: Grace Smith Bel Air maryland.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

Immediate cause (a) Coronary occlusion DUE TO

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (b) DUE TO (c)

INTERVAL BETWEEN ONSET AND DEATH: —

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION:

19b. MAJOR FINDING OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY

21c. (City or town) (County) (State)

21d. TIME (Month) (Day) (Year) (Hour) OF INJURY M.

21e. INJURY OCCURRED While at work ☐ Not while at work ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE Gerald C Palmer M. D.

CHIEF MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAM. ☒

DATE SIGNED 4/19/54

23. BURIAL, CREMATION, REMOVAL (Specify): Burial

DATE THEREOF 4/24/54

NAME OF CEMETERY OR CREMATORY Mountain cemetery

LOCATION (City, town, or county) (State) Bel Air R.F.D. maryland.

DATE REC'D BY LOCAL REG. 4/23/54

REGISTRAR'S SIGNATURE Priscilla Lowood

24. FUNERAL DIRECTOR John G. Farring ADDRESS aberdeen md.

3691

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Reg. Dist. 03697

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 185

1. PLACE OF DEATH: Harford COUNTY — Maryland MARYLAND
CITY (If outside corporate limits, write RURAL OR TOWN and give nearest town): Havre de Grace
LENGTH OF STAY (In this place): D O A
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Harford Memorial

2. USUAL RESIDENCE (HOME) OF DECEASED: Del. STATE — COUNTY
CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN: Delaware City
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED: (Type or Print) (First) J (Middle) H (Last) Hare

4. DATE OF DEATH (Month) (Day) (Year): April 16 19 54

5. SEX: MALE Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single
8. DATE OF BIRTH: 2 1898
9. AGE last birthday: Wt. 56 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): Late Man
10b. KIND OF BUSINESS OR INDUSTRY: Bacon Health Center
11. BIRTHPLACE (State or foreign country):
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Samuel H. Hare
14. MOTHER'S MAIDEN NAME: Ida May Wheeler

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service): W.W. I & 2
16. SOCIAL SECURITY NO.: Unknown
17. INFORMANT & ADDRESS: Mrs. Minnie Hatch, 3220 Abell Ave. Balto. Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH: — INTERVAL BETWEEN ONSET AND DEATH

4204

Immediate cause (a) Coronary Occulsion — —

DUE TO

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (b) DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION:
19b. MAJOR FINDING OF OPERATION:
20. AUTOPSY? Yes ☐ No ☒

21a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
21b. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
21c. (City or town) (County) (State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.
21e. INJURY OCCURRED While at work ☐ Not while at work ☐
21f. HOW DID INJURY OCCUR?

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE: Gerald C Palmer M. D.
CHIEF MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☒ ASSISTANT MEDICAL EXAM. ☐
DATE SIGNED: 4/16/54

23. BURIAL, CREMATION, REMOVAL (Specify): Burial
DATE THEREOF: 4/22/54
NAME OF CEMETERY OR CREMATORY: Arlington Nth.
LOCATION (City, town, or county) (State): Arlington Va.

DATE REC'D BY LOCAL REG.: Apr 20 54
REGISTRAR'S SIGNATURE: A. L. Lewis M. D.
24. FUNERAL DIRECTOR: Pennington & Son
ADDRESS: Havre de Grace, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A-5-53

RECEIVED
APR 22 1954
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

3692 **CERTIFICATE OF DEATH** 03698

Reg. Dist. No. 185

1. PLACE OF DEATH: COUNTY Harford MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Havre de Grace
LENGTH OF STAY (in this place) 16 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS Harford Memorial Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Harford
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Darlington
STREET ADDRESS (If rural, give location) c/o James E. Huff Jr.

3. NAME OF DECEASED (Type or Print) (First) Stanley (Middle) Joel (Last) Harry
4. DATE OF DEATH (Month) April (Day) 21 (Year) 1954
5. SEX Male
6. COLOR OR RACE White
7. SINGLE, ~~MARRIED~~, WIDOWED, DIVORCED (Specify) Widowed
8. DATE OF BIRTH 8/9/1877
9. AGE last birthday 76 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) State Road
10b. KIND OF BUSINESS OR INDUSTRY Retired
11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME Joel David Harry
14. MOTHER'S MAIDEN NAME Maria Jane Warner
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) No
16. SOCIAL SECURITY No. 216-28-2384
17. INFORMANT AND ADDRESS Mrs James E Huff Jr. Darlington, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Coronary [illegible]

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Arterio [illegible]

(c)

INTERVAL BETWEEN ONSET AND DEATH

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION —
19b. MAJOR FINDINGS OF OPERATION —
20. AUTOPSY? Yes ☒ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4-5, 1954, to 4-21, 1954, that I last saw the deceased alive on 4-21, 1954, and that death occurred at 6 a.m., from the causes and on the date stated above.

SIGNATURE [illegible] (Degree or title) ADDRESS Havre de Grace DATE SIGNED 4-21-54

23. BURIAL, CREMATION ~~REMOVAL (Specify)~~ Burial DATE THEREOF April 24, 1954 NAME OF CEMETERY OR CREMATORY Darlington Cem LOCATION (City, town, or county) Harford Co. (State) Md.

DATE REC'D BY LOCAL REG. Apr 23-54 REGISTRAR'S SIGNATURE A. L. Lewis M.D.
24. FUNERAL DIRECTOR H. S. Bailey ADDRESS Darlington, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

Item 18 Film G166 5/28/54 ams

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 03699

CERTIFICATE OF DEATH

3706

Reg. Dist. No. 182

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH:
COUNTY Harford — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Whiteford
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Harford
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Whiteford
STREET ADDRESS (If rural give location) R. D. 1

3. NAME OF DECEASED: (Type or Print) (First) Carrie (Middle) C (Last) Henry

4. DATE OF DEATH: (Month) April (Day) 14, (Year) 1954

5. SEX: Female

6. COLOR OR RACE: White

7. ~~SINGLE, MARRIED, WIDOWED, DIVORCED~~, (Specify) Widow

8. DATE OF BIRTH Jan. 27 1868

9. AGE Last birthday: 86 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired: Housework

10b. KIND OF BUSINESS OR INDUSTRY: at home

11. BIRTHPLACE (State or foreign country): York Co, Penna

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Thomas John Cooper

14. MOTHER'S MAIDEN NAME: Sara Bowne

15. WAS DECEASED EVER IN U.S ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service) No

16. SOCIAL SECURITY NO.: no

17. INFORMANT & ADDRESS: Miss Elsie Henry Whiteford, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) ABDOMINAL TUMOR. unknown as to malignancy

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.
(b) DUE TO
(c)

Interval Between Onset And Death: 5 YRS

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION 20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify) PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. INJURY OCCURED While at Work ☐ Not While At Work ☐ HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 3 ,1954, to APRIL 13, 1954, that I last saw the deceased alive on APRIL 13, 1954, and that death occurred at , from the causes and on the date stated above.
SIGNATURE (Degree or title) Charles A. Judd MD ADDRESS STREET MD DATE SIGNED 4-15-54

23. BURIAL, CREMATION, REMOVAL (Specify) Burial DATE THEREOF April 16, 1954 NAME OF CEMETERY OR CREMATORY Cooper Cem LOCATION (City, town, or county) (State) York Co, Penna

DATE REC'D BY LOCAL REGISTRAR April 15, 1954 REGISTRAR'S SIGNATURE C. H. Kirk

24. FUNERAL DIRECTOR H. S. Bailey ADDRESS Arlington Md

RECEIVED
APR [illegible] 1924
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

03700

3707

CERTIFICATE OF DEATH

Reg. Dist. No. 185

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Harford — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Havre de Grace
LENGTH OF STAY (in this place) About 35 yr.
HOSPITAL OR INSTITUTION OR STREET ADDRESS R. F. D. #1 Box 176

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Harford
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Havre de Grace
STREET ADDRESS (If rural, give location) R. F. D. #1 Box 176

3. NAME OF DECEASED (Type or Print): (First) Everine (Middle) H. (Last) Hilton
4. DATE OF DEATH: (Month) 4 (Day) 16 (Year) 1954

5. SEX: Female
6. COLOR OR RACE: Negro
7. SINGLE, MARRIED, (WIDOWED) DIVORCED, (Specify): Widowed
8. DATE OF BIRTH: ? ? 1865
9. AGE last birthday: 89 yrs. If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): New Haven, Conn.
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: No Record
14. MOTHER'S MAIDEN NAME: No Record

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): —
(If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.: —
17. INFORMANT AND ADDRESS: R. F. D. #1 Box 176 Mrs. Stella Jones - Havre de Grace, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

443.1
Immediate cause (a) Cerebral Vascular Accident

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last
(b)
(c) Hypertensive Cardiovascular disease

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4/9, 1954, to 4/16, 1954, that I last saw the deceased alive on 4/15, 1954, and that death occurred at 7:35 p.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED
George I. Stansbury, M.D. Havre de Grace, Md. 4/19/54

23. BURIAL, CREMATION, REMOVAL (Specify): Burial
DATE THEREOF: 4/21/54
NAME OF CEMETERY OR CREMATORY: Green Spring Cemetery
LOCATION (City, town, or county) (State): W. Havre de Grace Harford Md.

DATE REC'D BY LOCAL REG.: Apr. 20-54
REGISTRAR'S SIGNATURE: G. L. Lewis M. D.
24. FUNERAL DIRECTOR: Elmer E. Bullock
ADDRESS: Havre de Grace Md.

VS. A15

RECEIVED
APR 22 19
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3708 CERTIFICATE OF DEATH

03701 Reg. Dist. No. 82

1. PLACE OF DEATH:
COUNTY Harford — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Dublin
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2 USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md — COUNTY Harford
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Dublin
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED: (Type or Print) (First) Wm (Middle) E (Last) James
4. DATE OF DEATH: (Month) April (Day) 7 (Year) 1954
5. SEX: Male
6. COLOR OR RACE: White
7. ~~SINGLE, MARRIED, WIDOWED, DIVORCED~~ (Specify): Married
8. DATE OF BIRTH: March 10 1875
9. AGE last birthday: 79 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Farmer
10b. KIND OF BUSINESS OR INDUSTRY: Dairy
11 BIRTHPLACE (State or foreign country): Texas
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Susan Cole
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)
16. SOCIAL SECURITY No.: No
17. INFORMANT & ADDRESS: Mr. Lamar James

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH
Immediate cause (a) Congestive Heart failure — DUE TO
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) old age — DUE TO
(c)
Interval Between Onset And Death: 2 mo

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) — PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY — (CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY — INJURY OCCURED While at Work ☐ Not While At Work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7 am, 1954, to April 7, 1954, that I last saw the deceased alive on April 7, 1954, and that death occurred at 6 47 pm, from the causes and on the date stated above.
SIGNATURE (Degree or title) Malcolm Dudley Pullin MD — ADDRESS Darlington, Md — DATE SIGNED 4/9/54

23. BURIAL, CREMATION, REMOVAL (Specify) Burial — DATE THEREOF April 9 1954 — NAME OF CEMETERY OR CREMATORY Darlington Cem. — LOCATION (City, town, or county) Harford Co. — (State) Md
DATE REC'D BY LOCAL REGISTRAR April 8, 1954 — REGISTRAR'S SIGNATURE C. K. Kirk
24. FUNERAL DIRECTOR — ADDRESS H. L. Bailey, Darlington, Md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
APR 29 1
TAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

03703

3709 2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct answer is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH
COUNTY: HARFORD — STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: RURAL WILMA
LENGTH OF STAY (In this place): 25 YRS
HOSPITAL OR INSTITUTION OR STREET ADDRESS: ~~WILMA~~ STOCKTON RD

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: MARYLAN — COUNTY: HARFORD
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: WILMA
STREET ADDRESS (If rural, give location): STOCKTON ROAD

3. NAME OF DECEASED (Type or Print): (First) MARGARET (Middle) H. (Last) LANE

4. DATE OF DEATH: (Month) APRIL (Day) 25 (Year) 1954

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): MARRIED

8. DATE OF BIRTH: DEC 10 1883

9. AGE last birthday: 70 yrs. If under 1 year: Months, Days. If under 24 hrs.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSE WORK

10b. KIND OF BUSINESS OR INDUSTRY: AT HOME

11. BIRTHPLACE (State or foreign country): BALTIMORE, MD

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: ANTHONY HUGHES

14. MOTHER'S MAIDEN NAME: MARY SWEENEY

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO — (If year, give war or dates of service): —

16. SOCIAL SECURITY No.: NONE

17. INFORMANT AND ADDRESS: HARRY W LANE STOCKTON RD WILMA MD

18. MEDICAL CERTIFICATION

		Interval Between Onset and Death
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
422.1 **Immediate cause**	(a) CARDIO-RESPIRATORY FAILURE	1 HOUR
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) PULMONARY EDEMA	1 HOUR
	(c) ARTERIO SCLEROTIC CARDIOVASCULAR ~~DISEASE~~	7 YEARS
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	—	

19a. DATE OF OPERATION: —

19b. MAJOR FINDINGS OF OPERATION: —

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): —

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: — (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.: —

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4 JAN, 1954, to 25 APR, 1954, that I last saw the deceased alive on 17 APR, 1954, and that death occurred at 3:A m., from the causes and on the date stated above.

SIGNATURE: N.P. Sidwell — (Degree or title) MD — ADDRESS: Bel Air, Md — DATE SIGNED: 26 Apr 54

23. BURIAL, CREMATION, REMOVAL (Specify): BURIAL — DATE: APR 28-1954 — NAME OF CEMETERY OR CREMATORY: ST JOHN'S CEMETERY — LOCATION (City, town, or county): LONG GREEN — (State): MD

DATE REC'D BY LOCAL REG.: 4-27-54 — REGISTRAR'S SIGNATURE: —

24. FUNERAL DIRECTOR: Duffel Bros — ADDRESS: 7110 BELAIR RD

Film#G164 Item# 9 4/19/54 emf

03704

MARYLAND STATE DEPARTMENT OF HEALTH

3710

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 182

1. PLACE OF DEATH: COUNTY HARFORD MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN JARRETTSVILLE
LENGTH OF STAY (in this place) 6 MOS
HOSPITAL OR INSTITUTION OR STREET ADDRESS RFD #1

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE MARYLAND COUNTY HARFORD
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN JARRETTSVILLE
STREET ADDRESS (If rural, give location) RFD #1

3. NAME OF DECEASED (Type or Print) (First) MAGGIE (Middle) BELL (Last) LEE
4. DATE OF DEATH (Month) APRIL (Day) 9 (Year) 1954
5. SEX F
6. COLOR OR RACE WHITE
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) MARRIED
8. DATE OF BIRTH MAY 10, 1896
9. AGE last birthday 57/5/8 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME JOHN H. ADAMS
14. MOTHER'S MAIDEN NAME HENRIETTA HARMON
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 219-28-2801
17. INFORMANT AND ADDRESS HARRY LEE, JARRETTSVILLE, Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
420.1 Immediate cause (a)	CORONARY THROMBOSUS, ACUTE	15 MIN
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)	HYPERTENSIVE CARDIO-VASCULAR	
(c)	DISEASE WITH CONGESTIVE FAILURE	7 YEARS

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. OBESITY

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 25 JAN, 1954 to 9 APRIL 1954 that I last saw the deceased alive on 27 MAR, 1954 and that death occurred at 10:30 A.m., 9 APRIL 54 from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED
Philip W. Heuman M.D, 307 Hickory Ave., Bel Air, Md 9 APR 54

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE THEREOF 4/9/54
NAME OF CEMETERY OR CREMATORY Chestnut Hill Cemetery
LOCATION (City, town, or county) Forest Hill, (State) Md.
DATE REC'D BY LOCAL REG. 4/10/54
REGISTRAR'S SIGNATURE Chester L. Eckstein Priscilla Lowood
24. FUNERAL DIRECTOR Jacob Hartenstein, New Freedom, Pa.
ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
APR 14 1954
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

3698 03705

CERTIFICATE OF DEATH

Reg. Dist. No. 185

1. PLACE OF DEATH — COUNTY: Harford. MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN: Havre de Grace
LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Harford Memorial Hosp.

2. USUAL RESIDENCE (HOME) OF DECEASED — STATE: Maryland COUNTY: Cecil
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN: Perryville
STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last): ~~Love~~ Bennett Alexander Love
4. DATE OF DEATH (Month) (Day) (Year): 4 18 1954
5. SEX: M
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): W
8. DATE OF BIRTH: Aug. 12 1872
9. AGE last birthday: 81 yrs. If under 1 year: Months Days; If under 24 hrs.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Foreman
10b. KIND OF BUSINESS OR INDUSTRY: Carpenter, House
11. BIRTHPLACE (State or foreign country): Harford Co Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Washington Love
14. MOTHER'S MAIDEN NAME: Sarah Eliz. Thompson
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY No.: 216-18-4649
17. INFORMANT AND ADDRESS: Roland A. Love Perryville Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Cardiac failure 4221

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Arterio sclerotic Cardio vascular disease

(c) Pneumonia, Hypostatic

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Hypostatic pneumonia, gangrene rt. leg.

19a. DATE OF OPERATION: 4-16-54
19b. MAJOR FINDINGS OF OPERATION: Gangrene rt leg.
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURRED While at Work ☐ Not While At work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4-14, 1954, to 4-18, 1954, that I last saw the deceased alive on 4-18, 1954 and that death occurred at 12:25a m., from the causes and on the date stated above.

SIGNATURE: Wm. K. Srender (Degree or title) ADDRESS: 608 S Union, Hde G. DATE SIGNED: 4-18-54

23. BURIAL, CREMATION REMOVAL (Specify): Burial — DATE THEREOF: Apr. 21, 1954 — NAME OF CEMETERY OR CREMATORY: Mt. Carmel — LOCATION (City, town, or county) (State): Emmorton, Harford, Md.

DATE REC'D BY LOCAL REG.: Apr. 24-54 — REGISTRAR'S SIGNATURE: A. L. Lewis M.D. — 24. FUNERAL DIRECTOR ADDRESS: Howard K. Mc Comas & Son, Abingdon, Md.,

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
APR
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

03706

3694

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 185

1. PLACE OF DEATH COUNTY: Harford MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Havre-de-Grace
LENGTH OF STAY (in this place): 1 day
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Harford Memorial Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED STATE: Maryland COUNTY: Harford
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Jarrettesville
STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last): William Payne Norris.
4. DATE OF DEATH (Month) (Day) (Year): 4 11 1954
5. SEX: male
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): widowed
8. DATE OF BIRTH: 7/29/69.
9. AGE last birthday: 84 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired
10b. KIND OF BUSINESS OR INDUSTRY: Farmer
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Norris, William
14. MOTHER'S MAIDEN NAME: Elizabeth Payne
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT AND ADDRESS: Irene Anderson Jarrettesville Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
42c.0 Immediate cause	(a) Acute Coronary Occlusion	12 hours
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Hypertensive Arteriosclerotic Heart Disease	15 years
	(c)	

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. —

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan, 1949, to April 11, 1954, that I last saw the deceased alive on April 11, 1954, and that death occurred at 10 15 P m., from the causes and on the date stated above.

SIGNATURE: S. James Thomson Jr. (Degree or title) M.D. ADDRESS: Jarrettsville DATE SIGNED: Maryland.

23. BURIAL, CREMATION REMOVAL (Specify): Burial
DATE THEREOF: April 14 1954
NAME OF CEMETERY OR CREMATORY: Smith
LOCATION (City, town, or county) (State): New Park Pa

DATE REC'D BY LOCAL REG.: Apr. 15 54
REGISTRAR'S SIGNATURE: A. L. Lewis M. D.
24. FUNERAL DIRECTOR: Vincent Gibb ADDRESS: Fair Grove Pa

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

APR 1954
BUREAU V. S.

Film#G165 Item# 9
5/7/54 emf

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

03707

3695

CERTIFICATE OF DEATH

Reg. Dist. No. 185

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH: COUNTY Harford — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Perryville de Grace — LENGTH OF STAY (in this place) 8 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS Upper Memorial Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Cecil
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Liberty Grove
STREET ADDRESS (If rural, give location) —

3. NAME OF DECEASED (Type or Print): (First) Georgia (Middle) Suppora (Last) Preston
4. DATE OF DEATH: (Month) April (Day) 28 (Year) 1954
5. SEX: female
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): widow
8. DATE OF BIRTH: 9-27-1878
9. AGE last birthday: 75 yrs. If under 1 year: Months — Days — If under 24 hrs.: Hours — Min. —
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife
10b. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME: John A. Woodrow
14. MOTHER'S MAIDEN NAME: Lillie Lyons
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) — (If yes, give war or dates of service) —
16. SOCIAL SECURITY NO. —
17. INFORMANT AND ADDRESS: Ernest Preston — Perryville - Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

1524

Immediate cause (a) Perforated Ulcer through abdominal wall

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Cancer of Stomach

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION — 19b. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — (CITY OR TOWN) — (COUNTY) — (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURRED While at Work ☐ Not While At work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4-20, 1954, to 4-28, 1954 that I last saw the deceased alive on 4-28, 1954, and that death occurred at 7:15 P m., from the causes and on the date stated above.

SIGNATURE: Wm. K. Riddle (Degree or title) — ADDRESS: Havre de Grace — DATE SIGNED: 4-28-54

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE THEREOF: April 30/54 — NAME OF CEMETERY OR CREMATORY: West Bottingham Cem — LOCATION (City, town, or county) (State): Colora Cecil Co. Md.

DATE REC'D BY LOCAL REG.: Apr 28-1954 — REGISTRAR'S SIGNATURE: G. L. Lewis M D

24. FUNERAL DIRECTOR — ADDRESS: J. E. Tyson / Rising Sun Md

RECEIVED
APR 30 1954
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH 03708

2411 N. Charles Street, Baltimore

3711 CERTIFICATE OF DEATH

Reg. Dist. No. 182

1. PLACE OF DEATH — COUNTY: HARFORD — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: BEL AIR — LENGTH OF STAY (in this place): 15 YRS
HOSPITAL OR INSTITUTION OR STREET ADDRESS: RFD #2

2. USUAL RESIDENCE (HOME) OF DECEASED — STATE: MARYLAND — COUNTY: HARFORD
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: BEL AIR
STREET ADDRESS (If rural, give location): RFD #2

3. NAME OF DECEASED (Type or Print) (First) JOHN (Middle) HENRY (Last) RECTOR
4. DATE OF DEATH (Month) APRIL (Day) 19 (Year) 1954
5. SEX: MALE
6. COLOR OR RACE: WHITE
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) MARRIED
8. DATE OF BIRTH: 1869 10 DEC.
9. AGE last birthday: 84 yrs. — If under 1 year: Months, Days — If under 24 hrs.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): CARPENTER
10b. KIND OF BUSINESS OR INDUSTRY: Employed
11. BIRTHPLACE (State or foreign country): VIRGINIA
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: ALBERT RECTOR
14. MOTHER'S MAIDEN NAME: SUSIE TODD
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 218-16-0827
17. INFORMANT AND ADDRESS: MRS. VIOLA RECTOR, RFD #2 BEL AIR, Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

4.2 0.1
Immediate cause (a) Coronary Thrombosis — 2 hrs
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Hypertensive Cardio vascular disease — Over 3 yrs
(c) Arterio sclerosis

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. CEREBRAL VASCULAR ACCIDENT, OLD

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURRED While at Work ☐ Not While At work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 19 Jan, 1954, to 19 Apr., 1954, that I last saw the deceased alive on 19 April, 1954, and that death occurred at 8:45 P m., from the causes and on the date stated above.

SIGNATURE (Degree or title): Philip W. Heuman M.D. — ADDRESS: 307 Hickory Ave, Belair, Md. — DATE SIGNED: 19 April 51

23. BURIAL, CREMATION REMOVAL (Specify): BURIAL — DATE THEREOF: 4/22/54 — NAME OF CEMETERY OR CREMATORY: Mt. Zion Cemetry — LOCATION (City, town, or county) (State): RFD BEL AIR, MD.
DATE REC'D BY LOCAL REG.: 4/20/54 — REGISTRAR'S SIGNATURE: Priscilla Forwood — 24. FUNERAL DIRECTOR: Joseph T Foster - Bel Air Md — ADDRESS

VS. A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
APR 22 1954
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH 03709

2411 N. Charles Street, Baltimore

3696

CERTIFICATE OF DEATH

Reg. Dist. No. 182

1. PLACE OF DEATH: COUNTY Harford MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Bel Air
LENGTH OF STAY (in this place) Entire life
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY Harford
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Bel Air
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) (First) Charles (Middle) (Last) Sechrist
4. DATE OF DEATH (Month) April (Day) 10 (Year) 1954

5. SEX Male
6. COLOR OR RACE Wh.
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married
8. DATE OF BIRTH Mar 19-1904
9. AGE last birthday 50 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Steel Worker
10b. KIND OF BUSINESS OR INDUSTRY Bethlehem Steel
11. BIRTHPLACE (State or foreign country) Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Wm Sechrist
14. MOTHER'S MAIDEN NAME Ada Garvine

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO
16. SOCIAL SECURITY NO. 808-07-9426
17. INFORMANT AND ADDRESS Mrs Mary A. Sechrist Bel Air Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

5230 Immediate cause (a) Coronary Occlusion -- (Coronary Arteriosclerosis) 30 min.

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Chr. Pulmonary Silicosis (progressive) 15 yr.

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. None

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June, 1940, to April 10, 1954, that I last saw the deceased alive on April 2, 1954, and that death occurred at 10:50p m., from the causes and on the date stated above.

SIGNATURE Willard P. Hudson (Degree or title) M.D. ADDRESS Forest Hill, Md. DATE SIGNED 4-11-54

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE THEREOF April 14/54
NAME OF CEMETERY OR CREMATORY Bel Air Memorial Gardens
LOCATION (City, town, or county) (State) Bel Air, Md

DATE REC'D BY LOCAL REG. 4/12/54
REGISTRAR'S SIGNATURE Priscilla Fourwood
24. FUNERAL DIRECTOR Berg Funeral Home Red Lion Pa ADDRESS Pen Jos & Tate Bel Air Md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1

RECEIVED
APR 1
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 1903710

3712 CERTIFICATE OF DEATH

Reg. Dist. No. 182

1. PLACE OF DEATH:
COUNTY Harford MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Joppa-Md
LENGTH OF STAY (in this place) 50 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS Rural

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Harford
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN X
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED: (Type or Print) (First) Rose (Middle) Mary (Last) Snare
4. DATE OF DEATH: (Month) April (Day) 11 (Year) 1954

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single
8. DATE OF BIRTH: Sept 10-1871
9. AGE last birthday: 82 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired: Companion
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Adam Snare
14. MOTHER'S MAIDEN NAME: Mary Chetelat

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no (If Yes, give war or dates of service)
16. SOCIAL SECURITY No.: none
17. INFORMANT & ADDRESS: Mrs Harriett Howard

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

			Interval Between Onset And Death
446 X Immediate cause	(a)	Uraemia	6 wk
Antecedent causes(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.	DUE TO (b)	Nephrosclerosis	5 yr.
	DUE TO (c)	Arteriosclerosis	10 yr.

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. None

19a. DATE OF OPERATION: None
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify) None
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURED While at Work ☐ Not While At Work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from March 1953 to 4-11-, 1954, that I last saw the deceased alive on 4-5 1954, and that death occurred at 8:30 AM, from the causes and on the date stated above.
SIGNATURE Peter V. Rodman (Degree or title) M.D. ADDRESS Aberdeen DATE SIGNED Md 4/11/54

23. BURIAL, CREMATION, REMOVAL (Specify) Burial
DATE THEREOF Apr 13 1954
NAME OF CEMETERY OR CREMATORY St. Stephens
LOCATION (City, town, or county) Bradshaw (State) Md
DATE REC'D BY LOCAL REGISTRAR 4/12/54
REGISTRAR'S SIGNATURE Priscilla Forwood
24. FUNERAL DIRECTOR W.H. Archer ADDRESS Benson Md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECE
APR
BUREAU V. S.

Film#G164 Item# 13 4/19/54 emf

3697

03711
Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 1

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information if true, the correct, age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
COUNTY Harford MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Havre De Grace
LENGTH OF STAY (In this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md COUNTY
CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN Baltimore
STREET ADDRESS (If rural, give location) 4423 Marx Ave - ✓

3. NAME OF DECEASED: (Type or Print) (First) Anthony (Middle) J. (Last) Synodinos

4. DATE OF DEATH (Month) April (Day) 6 (Year) 1954

5. SEX: Male

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify):

8. DATE OF BIRTH:

9. AGE last birthday: 52 yrs. IF UNDER 1 YEAR: Months / Days; IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): Manager

10b. KIND OF BUSINESS OR INDUSTRY: Restaurant

11. BIRTHPLACE (State or foreign country): Greece

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: John Synodinos

14. MOTHER'S MAIDEN NAME: Carolyn Asmarana

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.:

17. INFORMANT & ADDRESS: Son Same

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:
Immediate cause (a) Fracture skull DUE TO
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (b) DUE TO (c)
INTERVAL BETWEEN ONSET AND DEATH: none

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION:

19b. MAJOR FINDING OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

21b. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: Susquehanna River

21c. (City or town) Havre de Grace (County) Harford (State) Md.

21d. TIME (Month) (Day) (Year) (Hour) OF INJURY 4/6/54 1P M.

21e. INJURY OCCURRED While at work ☒ Not while at work ☐

21f. HOW DID INJURY OCCUR? Plane crashed

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE Gerald C Palmer M. D.
CHIEF MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAM. ☒
DATE SIGNED 4/6/54

23. BURIAL, CREMATION, REMOVAL (Specify): Burial
DATE THEREOF 4-10-54
NAME OF CEMETERY OR CREMATORY Greek Cemetery
LOCATION (City, town, or county) Balto. (State) Md

DATE REC'D BY LOCAL REG. April 10, 1954
REGISTRAR'S SIGNATURE L L
24. FUNERAL DIRECTOR Lambros Funeral Home Inc. ADDRESS 440 E North Ave

VS. A15A - 5 - 53

THIS PERMIT MUST ACCOMPANY REMAINS TO DESTINATION

MARYLAND STATE DEPARTMENT OF HEALTH
Division of Vital Records and Statistics

Burial Permit No. .....

BURIAL—TRANSIT PERMIT

Full name of deceased Anthony T. Synodinos

Place of death Havre De Grace (City) Harford (County) Maryland (State)

Date of death April 6 1954 Sex Male Color White Age 52

Method of disposal Burial (Whether burial, cremation, transportation, storage, etc.) Greek Cemetery (Cemetery or Crematory)

County ..... State Maryland

A certificate of death having been filed as required by the laws of this State, permission to dispose of body of said deceased as above stated, is hereby given to Papulos Funeral Home (Funeral Director or person acting as such)

Address 440 E North Ave

Registration District No. ..... at ..... Date April 10 1954

Signature A. W. Ledrich (Registrar)

CEMETERY OR CREMATORY AUTHORITY SHALL FILL OUT SPACE BELOW

Body was Buried (State whether cremated, buried, stored, etc.) on 4-13-54 19... in Greek Orthodox Cemetery Evangeliamos (Cemetery or Crematory)

Place .....

Form V.S. A30
2-40—10M

SEE OTHER SIDE

Signature Nicholas A. Konstant (Sexton or person in charge)

This permit must be endorsed by the Sexton (or by the Funeral Director where there is no Sexton) and returned within 10 days to the Registrar of the district in which the burial takes place.

READ CAREFULLY

REGISTRAR: This burial-transit permit may be issued only upon receipt of a death certificate; not before. In special emergencies you may telephone the County or State Registrar of Vital Statistics, at the expense of the applicant, for instructions.

FUNERAL DIRECTORS: The burial-transit is required for any manner of disposition of a dead body including interment, storage, cremation, and transporation. A permit is required for each stillbirth, before disposal of the body.

When used as a transit permit for transportation by common carrier, this permit or a duplicate thereof should be enclosed in a strong envelope attached to the shipping case. No separate transit permit is required.

Before shipment by train or express, the body must be embalmed; or if that is not practicable, must be enclosed in a tightly sealed casket or outer case.

SEXTON: It is unlawful for any sexton, or other person in charge of a burial place, to permit burial or other disposition of a dead body before a burial-transit permit is deposited with him. (The sexton may accept the permit of any state, of the District of Columbia, Canadian Provinces or Mexican States, as authorization for burial.)

All permits must be endorsed, recorded in your sexton's register, and forwarded within ten days to the registrar for your district.

PENALTY for violations is from **$50 to $200** for each offense.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 3713 03712

CERTIFICATE OF DEATH

Reg. Dist. No. 182

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15—10-53

1. PLACE OF DEATH: COUNTY Harford MARYLAND; CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Street X; LENGTH OF STAY (in this place); HOSPITAL OR INSTITUTION OR STREET ADDRESS X

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Harford; CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Street X Rural; STREET ADDRESS (If rural give location)

3. NAME OF DECEASED: (First) Mary (Middle) J. (Last) Thompson

4. DATE OF DEATH: (Month) April (Day) 12 (Year) 1954

5. SEX: Female

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify):

8. DATE OF BIRTH: Dec. 23 1879

9. AGE last birthday: 74 yrs. IF UNDER 1 YEAR: Months Days; IF UNDER 24 HRS.: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework

10B. KIND OF BUSINESS OR INDUSTRY: at Home

11. BIRTHPLACE (State or foreign country): Harford Co Md

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Wm. J. Thompson

14. MOTHER'S MAIDEN NAME: Sarah R. Huff

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service) No

16. SOCIAL SECURITY NO. No

17. INFORMANT & ADDRESS: Oscar Thompson Street, Md.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.1

IMMEDIATE CAUSE (A) Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: 4/12/54

ANTECEDENT CAUSE (B) DUE TO Coronary Thrombosis. — 4/12/54

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) DUE TO Art. Sclerotic C-V Disease —

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Spondylitis.

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from ..... 1940, to April 12 1954, that I last saw the deceased alive on April 6, 1954, and that death occurred at 6:44 M, from the causes and on the date stated above.

SIGNATURE Louis A. Hunt M.D. ADDRESS Delta, Pa DATE SIGNED 4/12/54

23. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial | DATE THEREOF: April 16, 1954 | NAME OF CEMETERY OR CREMATORY: Friends Cem | LOCATION (City, town, or county) (State): Harford Co. Md.

DATE REC'D BY LOCAL REGISTRAR: April 14, 1954 | REGISTRAR'S SIGNATURE: C. W. Kirk

24. FUNERAL DIRECTOR: H. S. Bailey ADDRESS: Darlington, Md.

RECEIVED
APR 29 1954
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 03713

3714 CERTIFICATE OF DEATH

Reg. Dist. No. 182

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
COUNTY: HARFORD — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: CARDIFF
LENGTH OF STAY (in this place): 60 YRS.
HOSPITAL OR INSTITUTION OR STREET ADDRESS:

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE: MD. — COUNTY: HARFORD
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: CARDIFF
STREET ADDRESS (If rural give location):

3. NAME OF DECEASED (Type or Print): (First) JOHN (Middle) EDWARD (Last) WATSON

4. DATE OF DEATH: (Month) APRIL (Day) 7, (Year) 1954

5. SEX: M

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): MARRIED

8. DATE OF BIRTH: MAR. 29, 1869

9. AGE last birthday: 85 yrs. IF UNDER 1 YEAR: Months / Days; IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): MARBLE WORKER

10b. KIND OF BUSINESS OR INDUSTRY: MINING

11. BIRTHPLACE (State or foreign country): HARFORD CO. MD.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: JOHN WATSON

14. MOTHER'S MAIDEN NAME: MARY E. CONNELLY

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.: 220-07-8668

17. INFORMANT & ADDRESS: MRS. AGNES WATSON, CARDIFF, MD.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause: 420.1
(a) Myocardial Failure
DUE TO
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.
(b) Coronary Sclerosis
DUE TO
(c) Arterio Sclerotic C-V Disease

Interval Between Onset And Death:

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death: Ca Prostate & Pulmonary Metastasis — 4 yr.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURED While at Work ☐ Not While At Work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from ..., 1940., to April 7, 1954., that I last saw the deceased alive on April 7, 1954., and that death occurred at 1145, from the causes and on the date stated above.
SIGNATURE (Degree or title): Josiah A. Knott M.D.
ADDRESS: Delta Pa.
DATE SIGNED: April 8, 1954

23. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
DATE THEREOF: APR. 10, 1954
NAME OF CEMETERY OR CREMATORY: SLATE RIDGE
LOCATION (City, town, or county) (State): DELTA, PA.

DATE REC'D BY LOCAL REGISTRAR: 4/8/54
REGISTRAR'S SIGNATURE: Priscilla Forwood
24. FUNERAL DIRECTOR: JOHN H. HARKINS, DELTA, PA.
ADDRESS:

VS. A15

RECEIVED
APR 13 1954
BUREAU V. S.